

THE OPINION OF NURSES REGARDING THE WORK THEY PERFORM WITH FAMILIES IN THE FAMILY HEALTH PROGRAM¹

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This study aimed to learn the nurses' opinion concerning the work they perform with families in the context of the Family Health Program and which are the necessary competences to accomplish it. This is an exploratory-descriptive study, of qualitative nature, carried out with 20 nurses who worked at a Family Health Center. The data were collected through a semi-structured interview and the Bardin's referential was used for the analysis of content. The results revealed that the work with families is structured based on the actions and relationships existent between the professionals and the families, because the establishment and maintenance of such relations interfere in the quality of the assistance. Regarding the necessary competences, the importance of the scientific technical knowledge (know-how) and especially the ability to relate with the families and with other team members are emphasized. In addition, commitment, involvement and ethical posture were named, which are aspects easily reached when a person likes what (s)he does.

DESCRIPTORS: nurse's role; family health; family nursing; family health program

OPINIÓN DE ENFERMEROS CON RELACIÓN A LO QUE SIGNIFICA TRABAJAR CON FAMILIAS DENTRO DEL PROGRAMA SALUD DE LA FAMILIA

El objetivo de este estudio fue conocer la opinión de enfermeros sobre lo que significa el trabajo con familias dentro del contexto del Programa Salud de la Familia (PSF) y cuales son las competencias requeridas para este tipo de trabajo. Es un estudio exploratorio descriptivo, de tipo cualitativo, desarrollado con veinte enfermeros que trabajan en un PSF. Fue utilizada para la recolección de datos, la entrevista semi estructurada, y para el análisis de contenido de las entrevistas el fundamento teórico de Bardin. Los resultados demostraron que el trabajo realizado con las familias se estructura a partir de acciones y relaciones de los profesionales con las mismas, pues al establecer y mantener relaciones con la familia se interfiere en la calidad de la asistencia. Con relación a las competencias se resaltó, sobre la importancia del conocimiento técnico-científico (saber - hacer) y en especial del saber relacionarse (saber - ser) con las familias y con los miembros del equipo, demostrando compromiso, involucramiento y postura ética; aspectos más fácilmente conseguidos cuando se gusta de lo que se hace.

DESCRIPTORES: rol de la enfermera; salud de la familia; enfermería de la familia; programa salud de la familia

OPINIÃO DE ENFERMEIROS ACERCA DO QUE É TRABALHAR COM FAMÍLIAS NO PROGRAMA SAÚDE DA FAMÍLIA

O objetivo deste estudo foi conhecer a opinião de enfermeiros acerca do que é o trabalho com família no contexto do Programa Saúde da Família (PSF) e quais as competências necessárias para esse trabalho. Trata-se de estudo exploratório-descriptivo, de natureza qualitativa, desenvolvido junto a vinte enfermeiros que atuam em um PSF. Utilizou-se para a coleta de dados a entrevista semi-estruturada e para análise do conteúdo dos discursos, o referencial de Bardin. Os resultados revelaram que o trabalho com famílias é estruturado a partir de ações e relações dos profissionais junto às famílias, pois estabelecer e manter relações com a família interfere na qualidade da assistência. Em relação às competências, foram ressaltadas a importância do conhecimento técnico-científico (saber-fazer) e principalmente do saber se relacionar (saber-ser) com as famílias e com os membros da equipe, demonstrando comprometimento, envolvimento e postura ética, aspectos esses mais facilmente alcançados quando se gosta do que se faz.

DESCRIPTORES: papel do profissional de enfermagem; saúde da família; enfermagem familiar; programa saúde da família

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INTRODUCTION

In recent decades, the academy has taken increasing interest in the family theme, resulting in the greater inclusion of specific contents in subjects from different knowledge areas. In health, an increase has been observed in the number of studies, as well as in clinical practice directed at the family⁽¹⁾, strongly driven by the emergence of the Family Health Program (FHP). Nowadays, this program is considered more as a strategy to redirect the health care model.

According to the FHP, the family should be considered in its socioeconomic and cultural context and acknowledged as a space for interactions and conflicts that directly influence people's health. What family care is concerned, this strategy believes that the integral approach needs to include, among other issues, the conception of man as a social subject who is capable of outlining his own development projects and that care should focus on an individual with relations, as opposed to the biological individual⁽²⁾.

Hence, professionals working in this strategy must adopt differentiated attitudes, based on respect, ethics and commitment to the families they are responsible for, by creating bonds of trust and affection and by taking part in the construction of healthier environments in the family space⁽²⁾.

In practice, the strategy has faced some difficulties to sustain FHP team professionals' actions, as its theoretical framework has not been considered easy to read and its practical application still represents a challenge for active teams⁽²⁾. However, we believe that the main problem derives from the fact that the market does not offer a satisfactory quantity of qualified professionals with the profile to work in this new model, as neither professional education nor professional training has decreased this gap.

With respect to nurses, although nursing and the family have always been close, as care is inherent in both, the reality of working with families has basically covered orientation and the search for information, mainly in theoretical studies⁽³⁾.

Therefore, among other reasons, nursing work with families has been considered a challenge, which requires professionals to learn how to think of the family; to start developing a differentiated practice in the health and disease context, established on the basis of the family's own reality; and to contribute to the construction of nursing knowledge in the area.

From the perspective of the therapeutic approach, to refer to work as family care, the

professional needs knowledge about the family universe, as care delivery implies the ability to understand and adequately attend to the other person's needs. Scientific research has appointed some characteristics of family work, focusing on the world of its interactions, as these sustain and maintain the family core. This presupposes professionals' knowledge of family, family health and family interaction concepts⁽⁴⁾.

Several actions the professionals produce in the context of the FHP, (family registers, frequent home visits at times of changes in the phases of the family cycle and in case of acute or chronic diseases) favor interaction and bonding with the family. In practice, however, professionals often believe that they are delivering care to the family, even when their work process does not differ from the individual care process. In this case, what is actually happening is care delivery to an individual with relatives, instead of care to the family as a unit. And, however, there is a difference between care delivery to an individual who belongs to a family and care to the actual family, when care has its own characteristics and is developed on the basis of the universe of family relations⁽⁴⁾.

This confusion is even observed in scientific research, as some studies⁽⁵⁻⁶⁾ affirm, for example, that FHP nurses focus their care on the family and do not manage to demonstrate this when they describe the activities they perform. This is specifically the case for home visits which, although indicated as a family-oriented activity, are made in those cases when patients need special procedures⁽⁵⁻⁶⁾.

In the FHP scenario, families are addressed in different ways: family/individual, family/home, family/individual/home, family /community, family /social risk and family/family, but there exists neither mutual dialogue nor complementariness in this whole diversity, which makes it difficult to achieve care integrality and produces comprehension difficulties in planning, in care, in professional education advice, besides causing frustrations due to unattended expectations⁽⁷⁾.

It should be underlined that the FHP went through moments of reformulation, trials, expansion and that, nowadays, it has reached the age of facing challenges, an opportunity that demands targets to be reconsidered and courses to be readjusted⁽⁸⁾. This may be the appropriate time to reconsider or, better, delimit spaces, concepts and practices about work with families. And, as this work is new and, what is more, innovative, this demands a new disposition,

new mentality and new knowledge from nurses or any other professionals.

Research indicates that the FHP intensified and expanded nurses' activities in nursing care and education as well as in health service management⁽⁹⁻¹⁰⁾ and, also, that nurses' actions have been characterized as being compatible with the health surveillance model, represented by program and surveillance actions that, although directed at the community's health problems, are planned without their participation⁽¹¹⁾.

Thus, focusing on health and family care, in this study, we aim to examine nurses' opinions about work with families in the context of the FHP, defining the following study objectives:

- identify what it means to work with families according to FHP nurses from Maringá, PR;
- identify what competencies FHP nurses from Maringá, PR believe are necessary to work with families in the context of the FHP.

STUDY DESIGN

This descriptive, exploratory study with a qualitative approach was carried out in Maringá – PR and involved nurses working in the city's FHP.

The FHP was implanted in Maringá in 1999, initially with 7 teams. At the time of study, 62 teams were distributed among the 23 basic health units (20 in the urban zone, 2 in the districts and 1 in the rural area), distributed among 5 regional health units, which attended to 69.960 families, i.e. a populational coverage of 81%.

Study participants were 20 nurses, who were sorted, based on a list with the names of the 62 FHP nurses, distributed per BHU. The intent was to map the 20 BHU located in the urban zone, randomly selecting one nurses from each BHU, independently from the number of FHP teams allocated there. Data for the original study were collected between February and August 2004, through three different techniques: semistructured interviews, observation of home visits and patient file analysis.

In this paper, we have only used data from interviews that were previously scheduled by phone and based on a two-part script: the first with objective questions to identify sociodemographic characteristics; the second with eight open questions about the concept of family and family health and family work practice, which included a quotation and description of the

performed activities and the known and used techniques and instruments. All interviews were taped with the informants' consent.

The obtained data were processed according to Bardin's content analysis⁽¹²⁾. After transcribing the tapes, the material was read, starting the preliminary analysis and exploration of data. Next, data were systematically organized and grouped in units, which allowed for the exact description of relevant characteristics.

Then, categories were established, which consisted in isolating discourse elements and imposing a certain organization on the messages, examining what each of them holds in common with the other (activities that involve and that do not involve the family group) or, also, isolating them according to the previously proposed themes (family concept and performed activities). Next, based on the obtained data, inferences were made, using available material on the FHP and scientific studies on working with families as a theoretical reference framework, in the attempt to reach conclusions about the characteristics of work with families in the FHP.

The study complied with the ethical precepts for research involving human beings, ruled by Resolution No 196/96, and was approved by the Research Ethics Committee of Maringá State University (Opinion 159/2003).

RESULTS AND DISCUSSION

Getting to know the nurses under study

All nurses in this study were women, mostly young (45% up to 29 years and 35% between 30 and 39 years), half of them graduated for between 5 and 14 years and 45% for less than four years. Most participants (65%) had taken a specialization course, most of whom in an area complementary to their work (family health and collective health).

As to work in the FHP, most nurses (75%) were hired through a public selection process and have worked in the FHP for 3-4 years. Sixty percent have worked in the same team since the beginning. The hiring form was considered to be a factor that strongly influenced the professionals' permanence, qualification and performance, in view of the need to adhere to and incorporate new values and exercise new health practices. Moreover, precarious contracts have been indicated as factors of professional exhaustion and also rotation⁽¹³⁾.

Most participants (75%) mention an introductory training for the FHP and all of them received at least 1 (one) training in a specific area. However, only 15% report that the training was directly related to the family and FHP structure (sensitization and coverage area). The Ministry of Health stimulates the permanent education process, which should be conceived as a constant process of promotion and comprehensive development and placed in the context of the team. It should be focused on circumstances and problems in their work process, in a critical and creative way, transforming the work process and guiding them towards the constant quality improvement of health actions and services⁽¹⁴⁾.

In view of the lack of family-oriented contents and the emphasis on disease-oriented technical contents, the auxiliary/individual/uniprofessional model is still predominant in health services, which makes it difficult to practice FHP principles. Considering this aspect and the scarcity of professionals with a profile for FHP work in the job market, it is extremely important to develop and implement consistent permanent education programs, aimed at effectively supporting the work of FHP teams in the cities by overcoming the problems they face in daily work.

What it means to work with families

The nurses in this study consider that work with families is characterized by the professionals' actions and relations with the families.

Actions involve everything that is done in daily reality. Obtaining a family diagnosis is most frequently recognized as part of the reality of work with families.

The team arrives at the family, reaches a diagnosis, surveys problems, not only related to disease, everything involving the family... (N-18).

For you to work with families, first, you have to know that family.... (N-11).

The testimonies are directly related with the FHP model and the professionals' tasks, which are: understanding the family in an integral and systemic way, as a space for individual and group development that is dynamic and subject to crises; getting to know the reality of the families they are responsible for, particularly their social, economic, cultural, demographic and epidemiological characteristics and identify the most common health problems and risk situations that population is exposed to, among others⁽²⁾.

Delivering care to the family is another characteristic that is frequently mentioned as part of family work. This care is based on three points: focus, activities and structure. Some nurses explicitly mention that the focus of care is the family, although they adopt individual or individual-related care as a reference for family work.

For me, working with families means looking at each individual separately... (N-20).

... Individual care... (N-4).

FHP actions are configured on the basis of an integral approach of the family. Integral care includes, among other aspects, conceiving man as a social subject capable of outlining his own development projects. Thus, the focus of care should be an individual with relations, as opposed to the biological individual⁽²⁾.

The predominant health model in Brazil, characterized by individual, curative and excluding care, created a large distance between health teams and the population, and also marks health professionals' education; and, despite all efforts to change this reality, the old model still exerts a strong influence on the nurses' testimonies and actions.

However, it should be reminded that, alone, the principles and bases of the FHP cannot respond to the goal of inverting the auxiliary model, as such a change requires much broader actions than family health teams' intervention capacity, no matter how well prepared they are. In other words, structural changes are needed, related to the environment, economy, agricultural policy, social work, education and leisure⁽¹⁵⁾.

With respect to the second aspect of care - activities - these are interpreted as auxiliary and manifested in the first place through preventive guidelines. These activities mark the reality of Brazilian nursing work with families. This makes it necessary to stimulate a more advanced practice, considering the needs and health states of individuals in the family as well as its functioning, structure and functions. Hence, the assessment and care will focus on each individual's health as well as that of the family as a whole.

What the third aspect of care is concerned - structure - the nurses referred to the need for activity planning and to the fact that activities are performed by a multiprofessional team.

According to the FHP manual⁽²⁾, action planning is related to the capacity to diagnose the local reality, as well as to elaborate and evaluate work plans that produce the appropriate impact;

interdisciplinary work involves professionals from different areas, and sharing knowledge and information in favor of team work, so as to achieve a greater impact on the different factors that interfere in the health-disease process and contribute to the implementation of a more integral and problem-solving approach.

With respect to the second characteristic of family work the nurses appointed – the professional's relation with the families – two categories could be identified: establishing relations and maintaining relations with the family.

According to the nurses, establishing relations with the family is necessary for their work to evolve well.

Having a good bond to feel confidence... (N-5).

You have to get involved in everything to work with families... (N-7).

You have to conquer the family with a view to giving advice... (N-11).

But the concern cannot be limited to bonding, as maintaining the relation with the family is just as or even more necessary. For example, a respectful relation needs to be maintained for care to be effective.

There has to be respect, ethics... (N-11).

There has to be respect and confidence. (N-1).

It has to be a relationship of confidence and friendship. (N-4).

The perspective of the relationship rests on the triad of welcoming, listening and responsibility, as a process that starts in the professional's internal exercise with him-/herself. Welcoming and listening favor bonding and are translated in the professional's willingness to get involved and establish a relationship of trust and friendship. Responsibility is evidenced at the moment the nurse intends to respect the family and be ethical in his/her relations.

It can be perceived that the dynamics of the FHP favors the establishment of new relations and changes in the work process, but it needs to be understood that the meaning of welcoming goes beyond merely treating somebody well. It presupposes respect, interest and responsibility, not only for professional actions, but also for the population's problems and needs⁽¹⁶⁾.

It is interesting that the nurses appoint some benefits of work with families, which are perceived in the relational sphere, such as: easier Access and acceptance of the advice given. This, in turn, has benefited professional practice, as the intimacy,

confidence and bonds established with the family favor care quality, resulting, among other aspects, in greater gratification.

Although the relationships with the families are perceived as positive for the evolution of work, they are also perceived as a challenge, as knowing how to relate with others is one of the competencies needed to work with families, as illustrated below.

Competencies needed for work in the FHP

The nurses' opinion about the competencies needed to work with families, in the context of the FHP, gave rise to two categories: know-how and knowing-how-to-be.

The know-how category involves knowledge and actions related to the technical area, which can be detailed or described⁽¹⁷⁾, and covers technical (technical-scientific knowledge – procedures oriented towards the patient's physical problems) and organizational or methodical competencies (teamwork and planning)⁽¹⁷⁾.

The competencies they mentioned are in line with the work proposal configured by the FHP, which establishes tasks based on knowledge and actions for the entire team and specifically for each professional. Technical-scientific knowledge centers on know-how and procedures oriented towards the patient's physical problems⁽²⁾.

Within the conception of the FHP, it is fundamental to understand health as social production, as a constructive process a group can conquer in its daily reality. Thus, professionals refer to the nurse's capacity to deal with the community's social problems as a competence needed for work, as shown by the following declarations.

You need training to be able to deal with the community's problems ... (N-8).

A very large social view (N-9).

Being aware that you are going to work with social problems... (N-13).

The FHP recommends that the professionals get to know the factors (social, political, economic, environmental, cultural and individual) that interfere with the respective community's quality of life; articulate with other social sectors (organized social movements); stimulate the community's participation in the planning, execution and assessment of the Family Health Unit's actions and establish integrated actions in favor of the population's quality of life together with the local institutional network⁽²⁾.

Therefore, team professionals need to be prepared to solve the community's main health problems, organizing their activities around action planning (health care, promotion and surveillance), interdisciplinary teamwork and an integral approach of the family⁽¹⁾. It is highlighted that action planning refers to the capacity to diagnose the local reality, elaborate and assess work plans that can produce the appropriate impact.

Teamwork is needed to achieve the largest possible impact on the different factors interfering in the health-disease process and the integral approach of the family. It means approaching the family in its socioeconomic and cultural context, in health or disease situations, based on the valuation of aspects related to the family's dynamics, functioning, functions, development and to its social, cultural, demographic and epidemiological characteristics⁽²⁾.

Therefore, family health must be understood in the context of the relationships and interactions among its healthy and sick members, dimensioning the influence the individual's health exerts on the family group and vice-versa⁽⁴⁾. Thus, for work to be called family care, the professional needs knowledge about the 'family' universe, as care delivery implies the capacity to understand and adequately attend to other people's needs.

Therefore, for operational and communication goals, the professional or team that intends to work needs his/her/its own definition of family as, in a way, this indicates the extent of the look and intent to work with the families and can influence the professional's behavior, strengthening or stimulating behavior. Moreover, the professional or team works with the whole or with the parts⁽³⁾.

In the definition of family, the nurses considered the types, components and attributions of the family. As to family types, the emphasis on the social aspect stood out, which can be attributed to the nurses' work practice in the FHP, who selected the family and the home sphere as care foci and, in this environment, the professionals get to know/recognize the reality of the family's life, which is almost always permeated by the fight for better living conditions, also allowing for a broader understanding of the health-disease process.

In the presented definitions of family, psychological, biological and legal aspects were also highlighted⁽¹⁸⁾.

It is the set of persons who live together in the same place, under the same roof, with or without blood relationship. (N-19).

It is each person's world, the relationships, whom he considers as family. (N-16).

Family is father, mother and children. (N-3).

There are various types ... foster children. (N-9).

The nurses acknowledge a range of family compositions⁽¹⁸⁾, emphasizing alternative family characteristics.

It doesn't have to be father, mother and children, it can include brothers, colleagues... (N-17).

Of the extended family.

Family is... father, mother, grandparents, relatives (N-6).

Of the incomplete family.

...mother, children, aunt, it has changed a lot (N-17).

And also of the family nucleus.

Family is mother, father who takes care of the children (N-10).

The emphasis on the alternative family can be related to the acknowledgement of the multiple characteristics of the families the nurse relates with in daily work. In a way, family relationships have weakened over time and, amidst turbulences, the family attempts to get reorganized, reacting to and, at the same time, adapting to external conditioning factors, finding new ways of structuring which, in a way, reconstitute it, without a dominant pattern⁽¹⁹⁾.

Finally, in defining the family, the nurses also referred to its attributions, the main of which is care for its members.

It is one helping the other, it is partnership, love, affection, friendship, companionship... (N-3).

... mother, father who takes care of the children, or mother who has some time, teaches the child (N-10).

... it is the base for everything, education, support, mutual help...(N-15).

Family is who takes care, it's one person taking care of the other... (N-11).

The function the family is attributed can vary over time and depending on the culture. However, historically, its function has been to achieve economic survival, offer protection, transmit values and religion, educate the children and young people⁽¹⁸⁾.

Family care is characterized by actions and interactions present in the family core and is directed at each of its members, with a view to feeding and strengthening their growth, development, health and well-being. It can be recognized through countless attributes, especially: presence, protection, inclusion, orientation and education⁽²⁰⁾.

It should be highlighted that half of the nurses expressed difficulties to define family, referring to the concept as something difficult, different and complex.

Nowadays, it is very complicated for you to say what a family is, there are various types of family today, various family organizations... (N-9).

Nowadays, it is difficult to say what family is... (N-12).

This difficulty can partially be justified by the very meaningful family changes that have occurred in recent years, according to the specificity of each group or social class. Another difficulty can be attributed to FHP practice, which runs into the absence of a theoretical-practical framework that sustains and guides the inter-relational (to the detriment of technical) actions by each member and the team as a whole, in their interaction with the families, respecting their development cycles and the different moments and characteristics of their living experience.

These results lead to reflections about the nurses' need to take into account this reality of change and diversity in the family, and to seek theoretical support beyond the limits of the FHP, so that their work with families can be effective and achieve better results.

The category knowing-how-to-be refers to the nurses' behavioral characteristics, which can be understood as the capacity to relate with others and with oneself. The most emphasized competencies acknowledged as necessary for work in the FHP were related with knowing-how-to-be, which corroborate discussions about professional competency in nursing and have privileged a broader focus, overcoming the eminently technical view and valuing ethics and human relations⁽²¹⁾.

In this category, the most frequently mentioned characteristic was "to like what you do". The choice of the profession presupposes affinity with or a certain aptitude for the area, while the choice of work involves much more, includes the need to get into the labor market, the opportunities found and the need for personal and family sustenance, which often makes professionals choose work they do not like that much.

Nevertheless, the nurses seem to have visualized that their professional competency cannot be solely and exclusively adapted to market impositions, in a context of competitiveness and productivity, but should go beyond the employer's demands and aggregate personal values that provide internal satisfaction⁽²¹⁾.

First, profile to work with families. If he doesn't like to get into the house and get into a dirty place, see dirty people in a bad mood, weakened patients, see people be mistreated, if you don't have

this profile, love for the profession... In the first place love for the profession, you like to be a nurse and you like family health, it's no use, the nurse won't manage to cope with it, no (N-3).

Commitment, involvement and ethical attitude were other characteristics mentioned as competencies needed to work with families: *Being very committed and responsible for what you assumed (N-14); If I see their need I end up getting involved with them and let him get involved with me (N-17); It has to be very ethical, because we enter the house, mainly the nurse; there has to exist a bond, knowing how to listen, having the right attitude and training... (N-8).*

These characteristics seem to be connected with the way nursing work is configured in the FHP, mainly with the responsibilities they receive. The nurses' involvement and commitment with work have to occur critically, creating spaces to modify and renew their actions, so as to effectively guarantee the right to health. They can be identified on the basis of a critical attitude and constant inquiries about the goal of nursing work (why are to whom care is delivered), for what (in what way in order to contribute to maintain, modify or transform), with what (resources, established powers, work instruments) or, also, what ideology guides them in professional and social relations inside the health production process⁽¹⁵⁾.

It should be highlighted that involvement and responsibility do not only refer to the work practice (professional conduct and performed procedures), but mainly to the people involved in professional practice. Thus, in the relation with people, an ethical posture is essential to start bonding and achieve effective care and integrality. Each professional, internally motivated by his/her ethical-philosophical principles, is the person who relates with a team and with the families, in order to get to know, plan and advise for the sake of prevention.

CONCLUSION

The group of nurses in this study, who worked in the FHP in Maringá, PR, considers that work with families is structured on the basis of professionals' actions and relations with these families, which are understood on the basis of the social aspect, group variety and family care. Although the actions involve everything that is done in daily practice, the most frequently recognized characteristics of this work are the achievement of the family diagnosis and assistance, considering the focus, activities and structure. The intended focus is the family but, in

practice, the activities, which are auxiliary and manifested in the first place through preventive advice, are still directed at individuals, especially people with a health problem; with respect to the care structure, the group highlights the need to plan activities and the fact that they are carried out by a multiprofessional team.

The professionals also consider that this job requires establishing and maintaining relations with the family and that this is the base for the good development of the work, as facilitating access to the family and its acceptance of what the health team proposes interferes in the quality of the delivered care.

With respect to the professionals' competencies to work with families, the importance of technical-scientific knowledge (know-how) was

highlighted, translated by the recognition and appropriate approach of the health problem and the social aspects involved on the basis of team work and, mainly, of knowing how to relate (knowing-how-to-be) with the families and with team members, demonstrating commitment, involvement and an ethical attitude, aspects that are achieved more easily when people likes what they do.

The nurses' emphasis on knowing-how-to-be shows that the FHP has been a favorable scenario for critical and reflexive discussion with a view to overcoming the technicist, biomedical health care model. However, this requires cities to be more daring in permanent education of these professionals, so as to train them for daily management and also to lead to new practices and values.

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